STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G027	A. BUILDING _____ B. WING _____	09/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	3215 20TH STREET, NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This recertification survey was conducted from September 15, 2008, through September 17, 2008. The survey was initiated using the fundamental survey process. Six female clients with varying degrees of disabilities reside in this facility. Three of the six clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	W 000	Received 10/20/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interviews, and the review of records, the facility's governing body failed to provide general operating directions over the facility as evidenced by the following: The findings include: 1. The governing body failed to ensure medications were stored under proper conditions of security. [See W381] 2. The governing body failed to ensure that nursing services were provided in accordance with each clients needs. [See W331]	W 104	W 104 1. Reference response to W381. 2. Reference response to W331.	
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS	W 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 130	Continued From page 1 The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure clients residing in the facility were provided privacy during care of personal needs for one of the three clients in the sample. [Client #2] The finding includes: Observation on September 15, 2008, at approximately 7:10 AM, revealed Client #2 in the bathroom, located at the end of the hall, with the door open. Staff was observed assisting Client #2 with putting on her clothes while she was seated on the toilet. At the time of the observation, two clients were observed passing in front of the open door prior to the direct care staff closing the door. At the time of the survey, the facility failed to ensure Client #2's right to privacy while dressing.	W 130	W 130 QMRP conducted an in-service training on 10/14/08 which included respecting the privacy of the individuals supported. On an ongoing basis, the QMRP will conduct and/or coordinate relevant in-service training sessions to ensure that staff are trained on all specialty areas related to the GHRMP and residents to be served as indicated by the residents need. QMRP and Residence Manager will observe staff to ensure that training objectives are implemented consistently and provide retraining in accordance with regulation and as necessary based on observation of each supported individual's need/s. W 140 Response to W 140 on next page.	
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and the review of records, the facility failed to establish and maintain a system that ensured a complete and accurate accounting of clients' funds that were entrusted to the facility, for two of the six clients	W 140		

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W 140	Continued From page 2 residing in the facility. (Client #3 and #5) The findings include: On September 17, 2008, at approximately 2:45 PM, interview with the QMRP and the review of Client #3 and #5's financial records revealed the following: a. Client #3's personal account documentation reflected withdrawals of $380.00 on 4/18/08 and $160.00 on 2/22/08 (totaling $540.00). At the time of the survey, there were no receipts available to justify the expenditures. b. Client #5 personal account documentation reflected withdrawals on $735.00 on 4/18/08 and $100.00 on 3/4/08 (totaling $835.00). At the time of the survey, there were no receipts available to justify the expenditures.	W 140	W 140 a & b: The receipts for the withdrawals in the amounts of $380 and $160 for Client #3 and $735 for Client # 5 have been remitted and placed in the individuals financial books. b: It should be noted that Client #5's activity was a deposit and not a withdrawal. Residence Manager/QMRP will adhere to agency established individual account management procedures by submitting receipts for purchases within seven days and meeting with Accounting monthly to review financial activity/reconcile each account. Accounting will inform Director of Programs of outstanding receipts. Director of Programs in conjunction with Accounting will follow through to ensure that receipts are obtained and that on an ongoing basis, individual financial accounts are audited and reconciled monthly.	10/13/08-Ongoing
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all injuries of unknown origin and allegations of neglect were reported immediately to the administrator or to other official in accordance with State Law as required by DC regulation (22 DCMR Chapter 35 Section 3519.10), for four out of the six clients residing in	W 153	Response to W 153 on next page	

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W 153	Continued From page 3 the facility. (Clients #1, #2, #3, and #4) The findings include: The review of the facility's unusual incident reports and interview with the Qualified Mental Retardation Professional (QMRP) on September 15, 2008 at 10:45 AM, revealed the facility failed to report injuries of unknown origin and allegations of abuse and neglect as required; a. On October 1, 2007, a direct care staff observed a red mark (2.4 inches) on the front right shoulder of Client #1. b. On July 7, 2008, Client #4 was observed to have swelling of the right toe and was taken to the emergency room for evaluation and treatment. c. On June 5, 2008, an incident report revealed that while being transported in the van to her day program, Client #2's wheelchair tilted over and the client hit her head on the metal van lift. Reportedly, the client's wheelchair failed to be properly secured with the appropriate number of safety tie downs. Further review of the report revealed the client received an injury to her left ear and was taken to the emergency room for evaluation. d. On February 26, 2008, a direct care staff reported observing a large scratch on Client #3's lower back. e. On March 5, 2008, a direct care staff observed Client #3 with a bruise on her left arm.	W 153	W 153 a, b, d and e: The incident involving Client #1 that occurred on October 1, 2007, Client #4 on July 7, 2008, Client # 3 on February 26 and March 5, 2008 were submitted on 9/22/08. Further review of the above incidents revealed that the injuries sustained were of known origin, however incident reports did not reflect the complete details of each incident. c. The incident involving Client #2 that occurred on June 5, 2008 was submitted on 9/22/08. An investigation into this incident has been initiated. Incident Management Coordinator will forward the results of the investigation by 10/24/08. Staff will be retrained on incident management specifically describing/detailing the incident/s. Additionally, The QMRP/Resident Manager will be retrained on incident management to include weekly review of all data progress reports as well as data review requirements, reviewing the incident reports and ensuring that all incidents are reported to additional governing officials within 24 hours in accordance with regulatory requirements. The Incident Management Coordinator in conjunction with the QMRP will ensure that all incidents are submitted and investigated in accordance with regulatory requirements.	9/22/08-Ongoing 10/24/08 11/5/08 - Ongoing
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS	W 154		

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W 154	Continued From page 4 The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all injuries of unknown origin were thoroughly investigated for three of the six clients residing in the facility. [Client #1, #3 and #4] The findings include: Interview with the QMRP and the review of the facility's unusual incident reports on September 15, 2008, at approximately 10:56 AM revealed the following injuries of unknown origin were not investigated: 1. On October 1, 2007, a direct care staff observed a red mark (2.4 inches) on the front right shoulder of Client #1 2. . On July 7, 2008, Client #4 was observed to have swelling of the right toe and was taken to the emergency room for evaluation and treatment. 3. On February 26, 2008, a direct care staff reported observing a large scratch on Client #3's lower back. 4. On March 5, 2008, a direct care staff observed Client #3 with a bruise on her left arm.	W 154	W 154 Reference response to W153. Cross reference response to Licensure Report Citation I 379. Response to W 159 on next page	9/22/08-Ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a	W 159		

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W 159	Continued From page 5 qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The findings include: 1. The QMRP failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently. [See W130 and W474] 2. The QMRP failed to establish and maintain a system that ensured a complete and accurate accounting of client funds. [See W140] 3. The QMRP failed to ensure that Client #1 was taught to use her safety helmet. [See W436]	W 159	W 159 1. Reference response to Federal Deficiency Report Citation W 130 and W 174. Cross reference response to Licensure Deficiency Report Citation I 229. 2. Reference response to Federal Deficiency Report Citation W 140 3. Reference response to Federal Deficiency Report Citation W 436. Response to W 189 on next page	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently.	W 189		

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W 189	Continued From page 6 The findings include: 1. The facility failed to ensure direct care staff provided privacy to Client #2 while assisting her with dressing. [See W130] 2. The facility failed to ensure that direct care staff served food in a form consistent with dietary orders. [See W474]	W 189	W 189 1. Reference response to Federal Deficiency Report Citation W 130. Cross reference response to Licensure Report Citation I 229. 2. Reference response to Federal Deficiency Report Citation W 474.	10/14/08
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client had a comprehensive self medication assessment on file that depicted their current functional status in that domain, for one of the three clients (Client #3) included in the sample. The finding includes: Observation on September 15, 2008, at approximately 6:15 PM, during the medication administration, revealed Client #3 taking her medication (bubble packs) from the medication cabinet and placing them on the table with verbal prompting. Interview with the Trained Medication Employees (TME) revealed that Client #3 had been assessed by the nurse prior to her participating in a self-medication program and its implementation. Review of the medication administration records,	W 214	W 214 Self medication reassessment for Client #3 will be completed by the Delegating RN in conjunction with the QMRP on 10/31/08 and filed in Client #3's medical record. The Delegating RN and QMRP will meet with Residence Manager and Direct support staff to review/discuss results of the self medication reassessment. for Client #3 and provide training as applicable for existing, revised and/or new self medication program/s for Client #3 by 11/6/08. The individual's self medication assessment will be reviewed annually and updated as necessary based on the supported individuals need by the Delegating Registered Nurse in conjunction with routine, subsequent oversight by the Director of Health Services.	11/6/08 Ongoing

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W 214	Continued From page 7 directly after the medication pass, revealed that the self-medication objective only concentrated on the client's ability to consume her medication and to drink water from a cup. Further review of Client #3's medical records failed to provide evidence of a self-medication assessment that determined her functioning level.	W 214	W331 1. Reference response to Federal Deficiency Report Citation W 436. 2- 4. An in-service for nursing staff and Trained Medication Employee's Included a review of proper medication administration and documentation was	10/14/08
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure nursing services were provided in accordance with each clients needs. The findings include: 1. On September 15, 2008 at approximately 6:15 PM, interview with the QMRP and review of Client #1's Health Management Care Plan under the risk areas for Osteoporosis, ambulation and seizures, indicated that the client was at risk for falls and special precautions were described due to the episodes of seizures activity. Further review of the plan, did not include an adaptive support helmet was to be worn for safety as recommended by the HRC in June 2008. (See W436) 2. The facility's nursing staff failed to ensure client medication records were reviewed and maintained. [See W365] 3. The facility nursing staff failed to ensure that medications were administered in accordance with physician's orders. [See W368]	W 331	provided on 10/14/08 The Registered Nurse will regularly review, sign and monitor the MARs for completion. Additionally, The Director of Health Services will monitor/audit the individual's medical records medical records routinely to ensure compliance. Appropriate disciplinary action will occur for failure to comply with medication administration policies/procedures. Additionally the Delegating RN will conduct unscheduled medication administration observations to ensure physician orders are followed. 5. Reference response to Federal Deficiency Report Citation W 214. 6. Reference response to Licensure Report Citation I 229. Federal Deficient Additionally the Delegating RN will conduct unscheduled medication administration observations to monitor adherence to infection control practices.	11/6/08-Ongoing 10/30/08

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W 331	Continued From page 8 4. The facility nursing staff failed to ensure that prescribed medications were administered without error. [See W369] 5. The facility's nursing staff failed to ensure self-medication assessment were completed. [See W214] 6. The facility failed to ensure that the LPN employed infection control practices during the medication administration. [See W454]	W 331		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on observation, interview and record reviews, the facility failed to establish and maintain a system that ensured individual medication records were maintained, for four of the six clients residing in the facility. (Client #1, #2, #4, and #6) The findings include: On September 15, 2008, at approximately 9:00 AM, review of the Medication Administration Records (MARs), after the medication pass, revealed that the facility failed to ensure an effective system for maintaining each client's MAR as evidence by the following: a. Review of Client #6's MAR revealed that on 9/14/08, the 6:00 PM prescribed treatment dosage for both her Betamethasone DP Augmented 0.5% ointment (6 mg) and her	W 365	a-g: Delegating RN in conjunction with Director of Health Services will conduct a additional training with Trained Medication Employees and Nurses who administer medication. The in-service will include a review of the medication administration procedures with an emphasis on ensuring that the physicians order is cross referenced with the pharmacy label and MAR prior to administering medication and documenting properly on the MAR. The Delegating RN will conduct unscheduled medication administration observations to monitor proper procedures are followed. Appropriate disciplinary action will be administered to those that fail to adhere to proper administration procedures.	11/6/08

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W 365	Continued From page 9 Ketoconazole 2% cream were not signed off as being administered. b. Review of Client #4's MAR revealed that on 9/13/08, the 7:00 AM dosage of Alendronide Sodium UU 70 mg was not signed off as being administered. Additionally, on 9/12/08, the client's dosage of Folic Acid 0.4 mg was not signed off as being administered. c. Review of Client #2's MAR revealed that the client received a dosage of Calcarb w/vit D and her treatment Flovent HFA 220MCG AER W ADAP treatment for asthma . Review of the medication administration records for verification of the medication pass revealed that prescribed treatment dosage failed to evidence that the nurse initialed the client's medication records after her administration. d. Review of Client #6's MAR revealed that the MAR had not been initialed indicating the client's Nitroglycerin 0.4 MG/HR patch TD24 for angina had been removed at 12:00 midnight as ordered on 9/12/08 and 9/13/08. f. Review of the back of Client #4's September 2008 MAR (on 9/12/08) documented the following regarding the client's 6:00 PM dosage of Carbamazepine prescribed for seizures: "Punch wrong pill. Did not give". Further review of the MAR and interview with the nurse on duty failed to reveal information regarding what happened to the wrong dosage of medication punched in error. According to the nurse, when medication was punched incorrectly, the nurse was responsible for circling the entry	W 365	W 365 continued: In addition, the Delegating RN/Director of Health Services met with the nurse in question during the medication pass that she was scheduled to complete following the 9/17/08 survey (10/10/08) to follow up on concerns noted during the survey and to monitor the medication pass . On an ongoing basis, the Delegating RN/Director of Health Services on will routinely audit the medical records to ensure that nursing notes are thoroughly completed and reflect the follow up on all medical concerns including but not limited to detailing pertinent information relating to medication administration and treatments. The Delegating RN will also conduct unscheduled/random medication administration observations to monitor adherence to procedures Follow up as appropriate will occur for failure to comply with medication administration protocols.	10/10/08 Ongoing

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W 365	Continued From page 10 and providing full details as to what occured with the medication on the back of the MAR. A review of the nurses notes additionally failed to indicate any information about the dosage of Carbamazepine. g. Review Client #1's MAR revealed that the client received Keppra 100 mg for seizures and Oyster Shell Calcium w/vit D 500-200 tablet for nutrition. Further review of the records revealed that the nurse had initialed Nystop100000 U/G Powder as being administered, however, the treatment was not provided during the medication pass.	W 365	W 368	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered in accordance with physician's orders, for two of the six clients residing in the facility. [Clients #2 and #5] The finding includes: Observation of the medication pass on September 15, 2008, at approximately 8:15 AM revealed that the facility's nursing personnel failed to ensure Client #2 and #5's medication were administered as prescribed as evidenced below: 1. During the medication administration, Client #2 was observed receiving her Flovent HFA 220 mg AER with ADA. Interview with the nurse	W 368	Response to W 368 on the next page	

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W 368	Continued From page 11 revealed that the agency policy was that the client must receive prescribed medications one before and/or one hour after the designated time prescribed. Review of the medication administration records and the client's September 2008 physician's orders revealed that the treatment was to be provided at 7:00 AM. 2. During the medication administration, Client #2 was observed receiving Levothyroxine Sodium 100 mg. Interview with the RN on duty revealed that the LPN was to have administered the medication 30 minutes before her breakfast as prescribed by the physician. It should be noted that Client #2 had eaten breakfast approximately 30 minutes prior to the medication pass. 3. On September 15, 2008, at approximately 8:05 AM, Client #5 was observed during the medication administration to receive Levothyroxine Sodium 125 mg. Interview with the RN on duty revealed that the LPN was to have administered the medication 30 minutes before her breakfast as prescribed by the physician. It should be noted that Client #5 had eaten breakfast approximately 30 minutes prior to the medication pass.	W 368	W 368 Reference response to Federal Deficiency Report Citation W 365.	
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to store drugs under proper conditions of security.	W 381	W 381 Response to W 381 on the next page.	

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	09G027	A. BUILDING _____ B. WING _____	09/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	3215 20TH STREET, NE WASHINGTON, DC 20018

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W 381	Continued From page 12 The finding includes: Observation on September 15, 2008, at approximately 6:00 PM, revealed the QMRP administered the evening medication to Client #1. During the observation, the QMRP left the medication cabinet door open and unsupervised and went into the living room. Prior to leaving the office, the QMRP did not close and lock the medication cabinet where the client's medications were being stored.	W 381	An in-service for QMRP/nursing staff and Trained Medication Employee's included review of the training from the TME certification class on the proper storage of medication and was provided on 10/14/08. The Delegating RN will conduct unscheduled/random medication administration observations to monitor adherence to procedures Follow up as appropriate will occur for failure to comply with medication administration protocols.	10/14/08 Ongoing
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one of the three clienst in the sample was trained in the use of there adaptive equipment. (Client #1) The finding includes: On September 15, 2008, at approximately 2:15 PM, interview with the QMRP and the review of Human Rights Committee Minutes (HRC) dated June 2008 revealed: "Staff should encourage Client #1 to wear her protective helmet". Further interview with the QMRP revealed that	W 436		

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W 436	Continued From page 13 Client #1 did have a protective helmet, however, did not like to wear the helmet because it was not "aesthetically pleasing". According to the QMRP, the only two types of helmets offered were bicycle style helmets. At the time of the survey, the client was not observed to wear a helmet. Additionally, there was no evidence that a training objective had been established/implemented to teach or encourage the client to tolerate her helmet. Note: Client #1 had seizure disorder described as "temporal lobe partial complex seizures." In April 2008, Client #1 underwent surgery to implant a Vagus Nerve Stimulator due to her frequent partial seizures which reportedly were not responding to medications.	W 436	W 436 Review of Client#1's records indicate that there is no current physician's order, for Client #1 to wear a protective helmet. The Human Rights Committee meeting notes reflected the HRC's recommendations for Client#1 to be encouraged to wear a helmet. This recommendation will be discussed with Client #1's neurologist and primary care physician. In the event that the helmet is recommended by the physicians. The QMRP will ensure Client#1 is refitted for a helmet, presented varied helmets choices and encouraged to select from choices presented. QMRP will develop and ensure implementation a goal for Client #1 to tolerate wearing the helmet in timed increments based on baseline data. In the event that Client #1 refuses to tolerate wearing a helmet, a discussion will be held at the individual's understanding level, on the risks and benefits of wearing a protective helmet. Documentation that this discussion took place will be placed in Client #1's file. In the interim, the current risk management procedure outlined in Client #1's Health Management Care Plan for seizures and fall precautions will continue to be implemented to reduce the risk of injury.	11/6/08 11/6/08-Ongoing
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, the facility failed to ensure that its direct care staff maintained a sanitary environment to avoid sources and potential transmission of infections. The findings includes: The facility's medication nurse failed to ensure infection control practices were implemented during the morning medication pass. Observation of the medication pass on September 15, 2008, at approximately 7:59 AM, revealed the medication nurse gave Client #5 a blue plastic cup of water after administering her	W 454		

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W 454	Continued From page 14 medications. At approximately 8:05 AM, the medication nurse was observed to pour water into the same drinking cup used for Client #5, and gave it to Client #2 to use to drink water.	W 454	W454 After discussion with the nurse in question, it was revealed that the cup the water was poured from had not been used by any individual. However, because of the risk of cross-contamination, all staff will receive additional training on proper medication administration and infection control procedures by 10/30/08. The Delegating RN has scheduled an infection control refresher training for 10/30/08 to include Direct support staff and Nurses. On an ongoing basis, the Delegating RN will ensure that medication administration nurses/ trained medication employees are refreshed on medication administration protocols. Medication administration will be observed/monitored periodically by the Delegating RN to ensure adherence to infection control practices. Follow up action as appropriate will occur for failing to adhere to medication administration	
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to serve foods in a form consistent with dietary orders, for one of the three clients in the sample. (Clients #1) The finding includes: The facility failed to ensure that food was prepared in a form consistent with Client #1's prescribed dietary needs as evidenced below: Observation on September 14, 2008, at approximately 2:45 PM revealed that staff provided Client #1 with a small meal. The meal consisted of one chicken leg, potato salad, and collard greens. Client #1 began to eat and approximately (20) twenty minutes later had completed her meal. The form of the client's meal was not observed to be altered (chopped, ground, or cut up). Interview with the direct care staff after her meal, revealed that she was prescribed 6 small meals throughout her day. Interview with the QMRP at 3:15 PM confirmed that Client #1 had been assessed by the nutritionist and was prescribed a meal protocol for 6 meals per day.	W 474	Response to W474 on next page	

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W 474	Continued From page 15 Review of the nutrition assessment dated 8/6/08 indicated that the client was on a "1500 calorie Low Fat/Low Cholesterol, no added salt at the table/ cut food into bite size pieces/ small frequent meals(6 meals/day)" diet. Review of the physicians orders dated 8/19/08 revealed that Client #1 was prescribed a Low Fat, Low Cholesterol, No Added salt at the table chopped diet. At the time of the survey, the facility failed to ensure Client #1 received her meal in accordance with her prescribed diet.	W 474	The speech and language pathologist will be contacted to complete an assessment of diet modification needs. Delegating RN will facilitate the review/discussion of the results with the Primary Care Physician and obtain the necessary approval for recommendations regarding Client #1's diet/nutritional needs as applicable and discuss with the interdisciplinary team. The Delegating Nurse in conjunction with the Director of Health Services will facilitate the updates to the Physician's Orders as necessary to ensure that the official prescribed diet for Client # 1 is consistently represented in all relevant documents. QMRP will coordinate for all staff to receive training on the dietary needs of Client #1 following the nutritional assessment which will be conducted by the Nutritionist consultant. On an ongoing basis, the QMRP/Residence Manager/Delegating RN will audit the individual's medical and clinical records and continue to meet on a monthly basis to discuss the medical (including dietary) needs of the individuals per established agency procedures and coordinate supports as necessary. Director of Health Services/Programs will monitor routinely for compliance/follow through.	

Health Regulation Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from September 15, 2008 through September 17, 2008. Six female clients with varying degrees of disabilities reside in this facility. Three of the six clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	I 000	Received 10/20/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 I 040 Reference response to Federal Deficiency Report Citation W474	10/14/08 -Ongoing
I 040	3502.1 MEAL SERVICE / DINING AREAS Each GHMRP shall provide each resident with a nourishing, well-balanced diet. This Statute is not met as evidenced by: Based on observation, interview, and record review the GHMRP failed to serve each resident with a nourishing, well-balanced diet. The finding includes: See Federal Deficiency Report Citation W474	I 040		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to	I 090		

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I 090	Continued From page 1 ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: 1. An environmental inspection on September 17, 2008, revealed that Resident #5's dresser had a broken drawer. 2. There was a rotted and damaged door observed in the rear of the facility (back passage door to the plumbing beneath the house).	I090	I 090 1-2. Residence Manager has submitted a maintenance request to repair the broken dresser drawer for Resident #5 and to assess repair/replace the rotted and damaged door in the rear of the facility on 9/22/08 upon return from vacation with the individuals. Broken Drawer was repaired on 9/27/08 and determined that the door has to be replaced, and that rotten was not due to a plumbing concern but erosion from period of high rain during this past summer. The damaged door will be replaced by 10/31/08. On an ongoing basis, the Residence Manager will complete weekly environmental audit, QMRP will conduct environmental audits at a minimum of monthly and The Director of Programs will conduct an environmental audit of the facility at least quarterly to ensure that work orders have been addressed and assess interior /exterior maintenance. Documentation of the environmental audits along with applicable maintenance work orders will be filed in the office of the Director of Programs.	9/27/08 & 10/31/08 9/22/08-Ongoing
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation the GHMRP failed to lock caustic agents being stored. The finding includes: Observations during the environmental walk-through on 9/17/08 approximately 1:40 PM, revealed a variety of caustic agents (bathroom cleaner, toilet cleaner, glass cleaner, etc.) were being stored in the office closet unlocked.	I095	I 095 All cleaning agents have been removed and placed in a locked cabinet in the office on 9/17/08. A staff meeting was conducted on 10/14/08 during which staff were reminded to ensure that all cleaning supplies/caustic agents are stored in the locked cabinet. Residence Manager and QMRP will monitor ongoing to ensure that cleaning agents are stored out of direct reach of each resident.	9/17/08-Ongoing
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing			

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I 161	Continued From page 2 body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP governing body failed to review its policies and procedures annually. The finding includes: Review of the policy and procedures manual on September 17, 2008, failed to provide evidence that the agency's policy manual had not been reviewed and approved annually by the governing body as required. The last reveiw date was in 2006.	I 161	I 161 Review of the program policy manual maintained in the administrative office indicated that the policy and procedures manual was approved and reviewed by governing bodies on 9/27/07. A copy of the 9/27/07 review has been placed in the agency policies and procedures manual that is maintained in the facility. The agency policies and procedures manual is reviewed and approved annually during the last board meeting of the fiscal year with the most recent review occurring on 9/24/08. Copies of the governing body's review and approval of the agency policies and procedures have been disseminated to all facilities. QMRP will ensure that the most recent review and approval is maintained on file in the facility program and policy manual.	9/24/08-Annually
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to maintained each resident's funds received and disbursed. The findings include: See Federal Deficiency Report Citation W140	I 189	I 189 Reference response to Federal Deficiency Report Citation W140	
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by:	I 203		

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I 203	Continued From page 3 Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on 9/17/08 revealed that GHMRP failed to provide evidence of a current signed job descriptions for the four direct care staff. (Staff #1 and #2)		I 203 Copies of the current job descriptions were on in the Human Resources office in process of filing as evaluations for staff # 1 and #2 had been recently completed which included review and acknowledgement of their job descriptions. The Job Descriptions have been filed in the applicable personnel records. Human Resources will ensure that all personnel documents are filed in each staff's personnel file and conduct routine audits of the files to ensure that they are current.	10/14/08 -Ongoing
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure its staff received annual health screenings in the form and manner as required by this section. The findings include: Interview and review of the personnel records on September 17, 2008 revealed the GHMRP failed to have evidence of current health screenings for the primary care physician , one LPN, and the pharmacist.		I 206 Copies of the current health screenings for the Primary Care Physician, LPN and Pharmacist were on file in the Human Resource office and maintained in a separate confidential folder which was not presented during the 9/17/08 survey. Human Resources in conjunction with QMRP will ensure that all personnel records including the health screenings are available for review during the survey process. Personnel files will continue to be audited routinely by Human Resources in an effort to maintain compliance.	9/17/08- Ongoing
I 222	3510.3 STAFF TRAINING	I 222		

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I 222	Continued From page 4 There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel. The finding includes: See Federal Deficiency Report Citation W189		I 222 Reference Response to Federal Deficiency Report Citation W189	
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interview and review of training documents, the GHMRP failed to provide evidence to validate staff training as indicated by residents' need. The findings include: Interview with the QMRP and the review of the in service training records on 9/17/08, revealed the GHMRP failed to provide training on infection control, privacy, and the implementation of emergency procedures.		I 229 QMRP retrained the staff on 10/14/08 which included training on respecting the privacy of the individuals and emergency procedures. Review of the training records maintained in the administrative office evidenced that staff received training on Emergency Procedures on 11/9/2007 and Infection Control on 12/15/07. The Delegating RN has scheduled an infection control training for 10/30/08. On an ongoing basis, QMRP and Delegating RN will ensure that staff are trained on all specialty areas related to the GHRMP and residents to be served as indicated by the residents need. QMRP and Residence Manager will observe staff to ensure that training objectives are implemented consistently and provide retraining in accordance with regulation and as necessary based on observation of need.	10/14/08 -Ongoing 10/30/08 -Ongoing

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I 379	Continued From page 5	I 379	I 379 a. The incident for Client #4 that occurred on 7/7/08 has been submitted on 9/22/08 b. The incident report for Client #2 that occurred on 6/5/08 was submitted on 9/22/08. Response to I 379 is continued on the next page.	9/22/08
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to report to governmental officials within 24 hours in accordance with this regulatory requirement. The findings include: The review of the facility's unusual incident management system and interview with the Qualified Mental Retardation Professional (QMRP) on September 15, 2008 at 10:30 AM, revealed the facility failed to timely notify the to the governmental agency of the following incident(s): a. On July 7, 2008, Client #4 was observed to have swelling of the right toe and was taken to the emergency room for evaluation and treatment. b. On June 5, 2008, an incident report revealed that while being transported in the van to her day program, Client #2's wheelchair tilted over and	I 379		

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I 379	Continued From page 6 the client hit her head on the metal van lift. Reportedly, the client's wheelchair failed to be properly secured with the appropriate number of safety tie downs. Further review of the report revealed the client received an injury to her left ear and was taken to the emergency room for evaluation. c. On December 5, 2007, Client #3 was not feeling well and staff reported her condition to the nurse. According to the report, after the nurses evaluation, she instructed the staff to take her to the emergency room. Reportedly, upon completion of the evaluation Client #3 was diagnosed with pneumonia.	I 379	I 379 continued c. The incident report for Client #3 that occurred on 12/5/07 was submitted on 9/22/08. All of the above incidents were reported to another governing body and placed in the incident management database (MCIS). The QMRP will be retrained on incident management and ensuring that all incidents are reported to additional governing officials within 24 hours in accordance with regulatory requirements. The Incident Management Coordinator in conjunction with the QMRP will ensure that all incidents are submitted and investigated in accordance with regulatory requirements. Incident Management Coordinator will revisit the existing internal routing form and update as necessary to include updating the guiding information relating to how/what and to whom incident reports are submitted.	9/22/08-Ongoing
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to provided diagnosis, evaluation, treatment services and necessary follow up service to prevent deterioration or further loss of functioning for each resident in the facility. The finding includes: See Federal Deficiency Report Citation W214 and W331	I 401	I 401 Reference response to Federal Report Deficiency Citation W331	

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I 474	Continued From page 7	I 474		
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP's nursing staff failed to ensure medication administration records were maintained. without documentation error. The finding includes: See Federal Deficiency Report W365	I 474	I 474 Reference response to Federal Deficiency Report Citation W365	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0238	A. BUILDING _____ B. WING _____	09/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	3215 20TH STREET, NE WASHINGTON, DC 20018

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R 000	INITIAL COMMENTS A licensure survey was conducted from September 15, 2008 through September 17, 2008. Six female clients with varying degrees of disabilities reside in this facility. Three of the six clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. The findings include: Review of the personnel records on 9/5/08 at 1:30 PM revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file for one direct	R 125	R 125 The criminal background checks for direct care staff #1 and the QMRP were completed upon hire and on file in their respective personnel files. Personnel files will continue to be audited routinely by Human Resources in an effort to maintain compliance with regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 125	Continued From page 1 care staff (#1) and the Qualified Mental Retardation Professional.	R 125		